Series on Upscaling Innovations in Reproductive Health in Asia, No. 1

INDIA

Rural Women Take Reproductive Health Matters Into Their Own Hands:

Rural Women's Social Education Centre

By Sangeeta Subramanian Sokhi

The International Council on Management of Population Programmes

This case study was developed with support from the Ford Foundation.

The *Series on Upscaling Innovations in Reproductive Health in Asia* aims at programme managers, policy-makers and others involved in population activities. The case studies in the series document innovative programmes and projects in Asia in the areas of 1) comprehensive reproductive health programmes; 2) prevention of RTI/STD/HIV/AIDS in the context of MCH/FP programmes; 3) women's participation in decision-making, project design and implementation; 4) enhancing male responsibility and participation; 5) adolescent/youth sexual and reproductive health; and 6) maternal health. The cases are developed to provide a better understanding of issues on service delivery and programme management for reproductive health care.

The editors for this series are Sharifah Tahir, Aun Ting Lim and Jay Satia. Gillian Foo also contributed to the editing of this case study; and we thank Phang Choon Mee for her assistance on desktop publishing.

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Consultant – Health and Population Programmes

Commentary by Rashidah Abdullah,
Asian-Pacific Research and Resource Centre for Women (ARROW)

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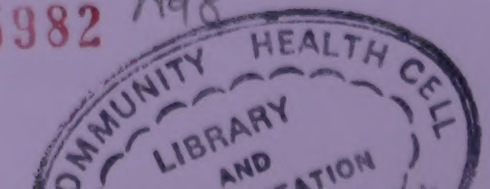

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A Commentary on RUWSEC
by Rashidah Abdullah *

The RUWSEC case study is useful and inspiring, for it provides in-depth information and insight into what a women-centred reproductive health approach actually means at field and organisational levels. There are very few models which have been documented and are available as guides for other organisations in the development of their programmes. Such models are critically needed to assist in swifter implementation of the Cairo and Beijing conference recommendations on women and health.

From the start, RUWSEC has been both women-centred and community-based in its values, objectives and strategies, and this clear framework has been a major organisational strength, enabling appropriate and successful programme implementation. Women-centred values of RUWSEC include the belief in women's right to control their bodies and lives, the belief that women experience subordination vis-à-vis men and that women have a right to demand quality health care. The community-based approach is founded on the conviction that the most economically and socially marginalised communities have the ability to collectively act to change their circumstances including their health. With these core values expressed, RUWSEC thus genuinely aims to continuously meet the needs of women and communities.

The key strategy to ensure that needs are met has been the establishment of an organisation which is in constant and close touch with the needs of various community groups, and of women in particular, through a number of innovative ways. These include the formation of womens' associations, employment of programme managers, administrators and health workers from the community itself and action research to determine current health needs. Behind the successful implementation of this strategy is the history that RUWSEC itself was founded by a group of women from the same community.

Comparing RUWSEC's programmes to the goals and standards set out in the Beijing Platform for Action's section on

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* Rashidah Abdullah is Director of the Asian-Pacific Research and Resource Centre for Women (ARROW) in Kuala Lumpur, Malaysia.

health, RUWSEC appears to be very on track. In terms of objectives, the reproductive health service programme aims to be affordable, accessible, comprehensive and sensitive to gender-issues. According on feedback from the community, it is achieving its objectives in practice. Realising that a focus on married women of child-bearing age alone will not address all of the health problems, the programme has expanded to include single women, older women, youth and men, in an attempt to meet the reproductive health needs of the whole community. RUWSEC's in-depth planning approach is shown by the understanding of the different needs of youth; that the "youth" category is not monolithic but comprises both married and unmarried young people, those in school, or working in the labour force and those working at household level.

In the difficult area of men's responsibility in reproduction and gender issues, RUWSEC has tried out some innovative ideas for reaching men through co-operation with men's community organisations. These new initiatives appear to be sustained and then evaluated rather than implemented as ad hoc one-off activities which is more common in other programmes. A total package of services is offered to men extending from education to clinic services. Analysis of gender relations and arising issues have been included in all education components of the programme including the youth programme. All of these aspects are not usually seen in conventional programmes.

It is apparent from the case study that RUWSEC is a very competent, professional and committed NGO. This is evident from the extent of detailed research and planning carried out before deciding on a new programme intervention, the evaluation process and indicators used as well as the personnel management processes. The programme is based on a sound assessment of women's health status, service provision and women's position (power relationships) in the home. In-depth needs assessment and action research have been critical to reviewing the programme and constantly checking whether the programme and services are still meeting community needs. Programme development and creative programme planning have thus been possible whereby RUWSEC has developed from a community-based organisation focusing on literacy and education to an organisation focusing on reproductive health

The programme includes single women, older women, youth and men to meet the reproductive health needs of the whole community.

including service provision and special programmes to people in need.

The case study points out some of the challenges in RUWSEC's future, one of the main ones being continuing to operate reproductive health services which are both caring and affordable as an alternative to the public health care system which is perceived by the community as inadequate. Although health services have been requested by the community in order to to meet their immediate needs, one does wonder if going into a service delivery role will allow enough time for the equally important role of lobbying the health care system to change. Which role will have more impact on community health in the long term? This needs to be carefully evaluated. It would also be very interesting to know how RUWSEC's reproductive health services actually differ in practice from government services from the perspectives of women themselves.

Impact indicators, apart from those described in the case study, which generally focus on primary health care, could include more measures on change in reproductive decision-making dynamics of women and men, women's knowledge of and attitude toward their bodies, understanding of men's and women's roles, change in the incidence of domestic violence and rape and other indicators of women's empowerment.

It is also important to know what kind of orientation and training is given to medical and community health workers of RUWSEC in women's rights and gender issues as the perspective and practice of personnel is critical to ensure a gender-sensitive organisation. This element is not mentioned in the case study. To what extent is gender awareness part of the organisational culture? How do women and men relate to each other as colleagues? Is RUWSEC more women-centred in its personnel policies regarding maternity leave, flexi-hours, breast-feeding etc. than other organisations?

There are a number of areas such as these which in the management of RUWSEC can be examined more closely to identify important lessons learned. And one can expect many lessons from this rich experience of a creative and very committed women's NGO. □

LIST OF ABBREVIATIONS

ANM	Auxiliary nurse midwife
CHW	Community health worker
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IUDs	Intra-uterine devices
NAEP	National Adult Education Programme
NGO	Non-governmental organisation
OB/GYN	Obstetrician/gynaecologist
PHC	Primary health centre
RTIs	Reproductive tract infections
RUWSEC	Rural Women's Social Education Centre
SDT	Social Development Trust
SED	Social Education for Development
STDs	Sexually transmitted diseases
VDRL	Venereal Disease Research Laboratory

India was one of the first countries to have an official family planning programme way back in the 1950s. Renamed as Family Welfare in the 1970s, the programme was essentially one of fertility control and fertility reduction. Other reproductive health problems of sexually active men and women were not addressed by the programme. However, with the emergence of HIV/AIDS as a major public health issue, the link with the spread of HIV and other sexually transmitted diseases (STDs), and due to the commitment made after the International Conference on Population and Development (ICPD) in 1994 in Cairo, Egypt, the Government began to look at how best to address the reproductive health needs of the community.

The Government recently finalised a Reproductive and Child Health Programme with support from the World Bank (Department of Family Welfare, 1995).[1] Its approach aims to help couples meet their reproductive goals and health needs while giving special attention to quality of care. The Government has also in principle agreed to move away from method-specific contraceptive targets to more comprehensive health indicators for evaluating performance and is currently in the process of finalising an alternative system of monitoring.[2]

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[1] The Government of India has since approved the Reproductive and Child Health Programme. Several districts in each state have been chosen to pilot test this new approach.

[2] This system was approved in April 1996 and is being field-tested in several districts in each state.

Rural Women Take Reproductive Health Matters into Their Own Hands: Rural Women's Social Education Centre

The Context

Community-based studies of the prevalence of STDs and reproductive tract infections (RTIs) are limited. One of the well-known community-based studies on gynaecological morbidity was conducted by Drs. Abhay & Rani Bang in Gadchiroli, Maharashtra,[1] in which findings showed that over 90 per cent of the women examined had symptoms of RTIs and less than 10 per cent had ever sought treatment. Baroda Citizen Council, et al. (1994)[2] conducted four community-based studies in geographically and culturally distinct areas of India, two in slum areas of Bombay and Baroda and one each in rural West Bengal and Gujarat. These studies showed that gynaecological morbidity based on clinical examination ranged from 26 per cent in Baroda to 43 per cent in rural West Bengal and Gujarat to 74 per cent in the Bombay slum. Cytological screening of 117,411 women attending gynaecology clinics of seven hospitals in Delhi[3] showed that only about 26 per cent of the smears were normal while the remainder were diagnosed with inflammation (72.3 per cent), dysplasia of various grades (1.6 per cent), and malignancies (0.1 per cent). More and more studies are generating findings similar to the above.

The scenario, therefore, is that everybody involved in public health issues whether in the government, academia, research or a service centre recognises that reproductive health problems have been neglected for far too long and that unless programmes are designed and implemented to provide quality reproductive health services to the larger community, the country faces a public health disaster. Programme managers and service providers in the government have also begun to realise that providing good quality, comprehensive reproductive health education and services will increase the acceptance by the community for these services including, especially, family planning. Presently, most reproductive health programmes being implemented in various parts of the country are by non-governmental organisations (NGOs). The programme being implemented by the Rural Women's Social Education Centre (RUWSEC) in Chengalpattu, Tamil Nadu, South India, is one example and is acknowledged to provide quality services which are accessible, affordable and gender-sensitive.

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1 Bang, R., Bang, A., Baitule, M., Chaudhary, Y., Sarmukaddams, Y. and Tale, O. T. "High Prevalence of Gynaecological Diseases in Rural Indian Women." *The Lancet,* 1:85-88.

2 Latha, K., Kanani, S. J., Maitra, N. and Bhatt, R. V. (Baroda Citizens Council); Senapati, S K. and Bhattacharya, S. (Child-in-Need-Institute); Sridhar, S., Giri, G. B., Shah, S. P., Shah, P. P. and Desai, L. A. (Society for Education, Welfare and Action-Rural); Parikh, I., Taskar, V., Dharap, N. and Mulgaonkar, V. (Streehitakarini). "Prevalence of Clinically Detectable Gynaecological Morbidity in India: Results of Four Community-based Studies." Unpublished paper, The Ford Foundation, India, 1994.

3 Luthra, U. K., Murthy, N. S., Sehgal, A., Mehta, S., Saxena, B. N., Ghargava, N. C. and Ramachandran, P. "Reproductive Tract Infections in India: The Need for Comprehensive Reproductive Health Policy and Programmes," in *Reproductive Health Infections,* eds. Germain et al. (New York: Plenum Press, 1992).

What is RUWSEC?

The Rural Women's Social Education Centre (RUWSEC) is a community-based NGO in South India that focuses on the rights of women within their households; these include their reproductive rights as well as rights to their overall well-being. This orientation is a direct result of the conviction arising from women's own experiences that they cannot become successful agents of social change without first having control over their bodies and their lives. Interpreting health in its broadest sense as overall 'well-being', the organisation's objectives include helping women belonging to the lowest caste groups, who are, as a result, economically backward and socially marginalised, to develop critical consciousness and leadership skills so that they are able to collectively and constructively change the circumstances of their lives. This group seeks to challenge the class, caste as well as gender-based subordination which compromise women's well-being.

People have to be organised to demand the fulfilment of conditions that make it possible for them to be healthy.

RUWSEC has sought to demystify the notion that health may only be 'delivered' by doctors, and believes that people have to be organised to demand the fulfilment of conditions that make it possible for them to be healthy. Through health education and awareness-raising programmes seeking to empower women with a sound information base, and through programmes aimed at enhancing their self-image and self-confidence, RUWSEC seeks to enable women to initiate self-help at home. It also tries to encourage women to be discriminating and well-informed users of health services and to feel entitled to quality health care, be it from the government public health system or private practitioners.

In 1995, RUWSEC's activities covered 43 hamlets with a total population, including men, women and children, of 15,000. From 1996, the organisation further expanded its activities to another 57 hamlets bringing the total number of hamlets covered to 100 with a total population of over 30,000.

A Beginning for RUWSEC

Kamala lives in a small village in Tamil Nadu, a southern state of India. She attended primary school but did not get a chance to go on to secondary level. She had to quit to perform household chores and other "women's" work. In 1981, Kamala had a break. She was one of several women in her village who were chosen by the National Adult Education Programme (NAEP) initiative of the Government of India to be trained as educators and in turn teach members of her community.

Kamala and her friends met regularly in a group to discuss their work and problems. These women were brought closer together by conflicts in the domestic front, opposition from male leadership in their communities and other concerns such as the need to know more about the many reproductive health concerns that they had. After meeting regularly for several months, some of them expressed the desire that the experience of meeting together as women to address gender issues and issues about reproductive health and rights should be extended to other women's groups in their respective villages. After two years of ad hoc meetings and numerous workshops with women in different villages, Kamala and her friends, 12 *dalits* (scheduled/backward caste) women, and a woman official of the NAEP decided to formalise the group and subsequently the formation of RUWSEC.

Profile of Population Covered

This description of the population covered is of the original 43 hamlets which, until recently, formed the core of RUWSEC's activities. The women reached belong to a section of the rural population that suffers extreme social and economic deprivation. About 60 per cent of the women come from households that are totally landless and about 80 per cent of these households do not even own the land on which their huts stand. This group is almost completely dependent on agricultural wage labour for its subsistence. Eighty-five per cent of the women do not have a single year of schooling, but are forced to seek work for their families' subsistence. Non-participation in the work force is related to women's reproductive responsibilities, being greater among young mothers than any other demographic or socio-economic category.

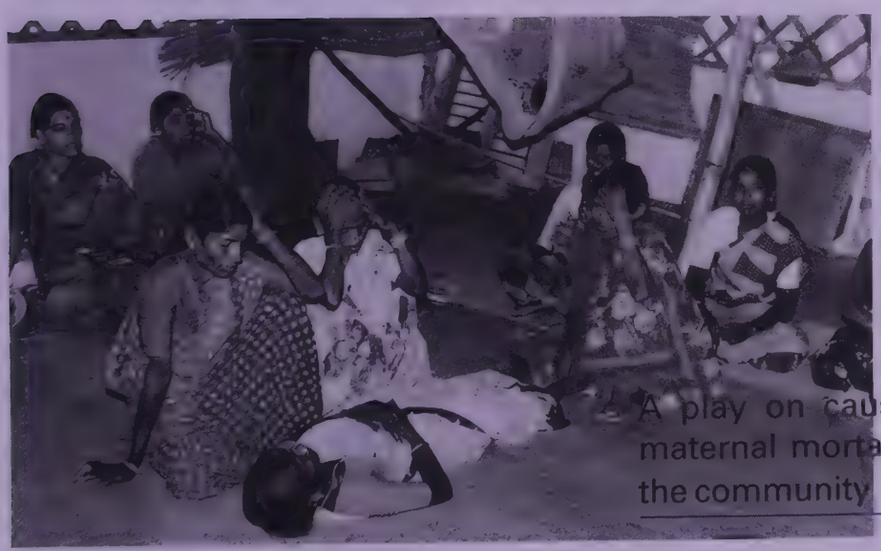
Only two per cent of the women are engaged in salaried employment, usually in their own villages as teachers and helpers in government-sponsored *balwadis* or childcare centres. Wages in agricultural employment are very low and do

not exceed Rs. 10 per day (about US$0.30), barely sufficient to buy one kilo of rice, the staple diet. Working hours, on the other hand, can extend from dawn to dusk and, in peak seasons, even longer.

Housing conditions are poor, and water or sewage systems are grossly inadequate. Public wells and taps are the main sources of water for all purposes. Water supply is erratic, especially in the summer months, and gathering water from taps may take several hours every day. Toilets are virtually non-existent.

Health Status of the Women[*]

In 1988-89, RUWSEC's community health workers carried out a baseline survey in the 43 hamlets they had been working in. The main objective was to establish the health and socio-economic status of this community. The survey found that the vast majority of women marry and begin childbearing while still in their teens. Forty-two per cent of the women suffer from one or more serious problems related to pregnancy and childbirth. Most of these are related to complications of delivery. Seventy-five per cent of all previous deliveries to women covered by the survey take place at home, a figure greater than that for rural India as a whole (around 60 per cent).



A play on causes of maternal mortality in the community

Growing up in landless families, children, especially girls, drop out early from school and join the labour force. Most girls are married by the time they reach their sixteenth birthday and are under tremendous social pressure to bear children immediately, a situation typical of a group with high infant and child mortality. The stillbirth rate is 29.8 per 1,000 live births, more than twice the rate for rural India (13.9/1,000 live births) and 1.5 times that of rural Tamil Nadu (17.8/1,000 live births). The under-five mortality is high at 184 per 1,000

[*] "Women" refers to all women of reproductive age, i.e. 15-44 years of age.

births; this clearly exceeds the estimated figure of 114 for the state as a whole. Inadequate nutrition coupled with heavy manual labour and low age at childbearing lead to high pregnancy wastage which in turn extends the period of child bearing to the entire reproductive span. Women start childbearing while still in their teens and conceive even when they are in their early forties. It is not uncommon to see mother and daughter pregnant at the same time. Worth noting is that in an economically and socially deprived group such as this, participation in the work force is not an indicator of better status but of greater deprivation.

The low priority accorded to women's health is reflected in patterns of health care utilisation. For instance, women are permitted trained attendance only for the first delivery or when they are very young. While begetting the first offspring is a high priority, precious resources are not invested in an additional child for a woman who already has three or more children notwithstanding the fact that the higher order births are riskier and may require medical attendance.

Women start childbearing while in their teens and conceive even in their early forties. It is not uncommon to see mother and daughter pregnant at the same time.

This pattern is in direct contrast to the pattern of health care utilisation in case of illness. Young women, especially teenagers, do not take any action whatsoever for their illness, while women in their early thirties and women wage workers take some form of action immediately. This is because a few days immobility and loss of wages for women with several dependant children are unacceptable from the family's point of view. Thus in addition to the constraints imposed by poverty, the main barrier to women's utilisation of health care is related to how the society values them.

A third of the women suffered from reproductive health problems at the time of the baseline survey. These range from problems associated with menstruation and urinary and reproductive tract infections, to more serious conditions such as uterine prolapse, urinary incontinence and cervical cancer.

Data collected in 20 hamlets by health workers for an eight-month period between February and May 1990, and in the same months in 1991, have provided RUWSEC with an indication of the extent, causes and determinants of health problems suffered by married women of reproductive age, and

have helped shape the direction of the organisation's reproductive health interventions (Tables 1 and 2, Annex 1). Some of the important findings to emerge from this study are:

- Prevalence and recurrence of health problems are high: 45 per cent of women have experienced at least one episode of a health problem during the eight-month period and each of these women has experienced an average of three episodes of illness.
- The average number of episodes for reproductive health problems is 2.1 and that for other health problems is 2.6.
- The most prevalent and frequent problem among the women who have a reproductive health problem is reproductive tract infections (RTIs), characterised by purulent white discharge with soreness, irritation and itching, and sometimes, severe lower abdominal pain.
- RTIs recorded above are mostly non-sexually transmitted infections such as bacterial vaginosis and candidiasis.
- The next most common and frequent reproductive health problem is urinary tract infections.
- Menstrual disorders affect 10 per cent of women with a reproductive health problem.

REPRODUCTIVE HEALTH PROGRAMMES

The Scope of RUWSEC's Programmes

Originally an education group for women, RUWSEC has, since late 1981, become an organisation that implements a wide spectrum of activities which may be divided into the following major programmes:

- Community-based action for health promotion and education
- Women's development
- Youth programme
- Programme for men
- Publication and distribution of popular education material on health
- Action research
- Reproductive health clinic

The community-based action for health promotion which was started in late 1981 forms the foundation for all RUWSEC's current activities. RUWSEC's strategy for health promotion in the community is to hire a local woman and train her as a community health worker (CHW). She then mobilises a core group of women as informal leaders from her village to form a women's *sangham* (association). These informal leaders may or may not be educated. They are usually married with two or more children, have shown interest in being more actively involved in the organisation's activities, and have demonstrated some leadership qualities within the village *sangham.*

These *sanghams,* whose membership sizes vary, act as pressure groups and catalysts initiating and engaging in a wide range of health promotion activities. The premise for this strategy is that the process of coming together to discuss their problems as women and to demand their health and reproductive rights would encourage the women to challenge other dimensions of their subordination as women, wage labourers and *dalits.* This case study focuses on the dimension pertaining to RUWSEC's reproductive health programmes only.

Leadership training for *sangham* members is carried out during fortnightly village meetings and inter-village workshops conducted three times in a year, which bring together women leaders from several villages to interact with one another. These workshops deal with a variety of themes related to women's health and their lives, information about macro forces affecting their well-being, and also with development of leadership and organising skills. The process of empowering the CHWs

Empowerment of Women: RUWSEC's Approach

Identify local women as CHWs
⇓
Train CHWs
⇓
CHWs form *sanghams* ⇐ Ongoing leadership training during fortnightly meetings
⇓
Initiate health activities ⇒
- Educate women in the community to demand their rights
- Organise education campaigns

The strategy of forming *sanghams* and providing leadership training to village women has created groups that are largely self-sustaining.

has come to the stage where they are able to conduct these workshops themselves, with the exception of topics such as legal aid where resource persons are brought in from other NGOs in the area. RUWSEC's approach is summarised in the following diagram.

In addition, special campaigns are launched on the basis of priority issues identified from time to time by the health workers during their interaction with the women's *sanghams*. An ongoing campaign that RUWSEC has actively led since 1988 concerns maternal mortality and morbidity. Several activities have been initiated including studies to identify the major problems and the efficacy of interventions. Other campaigns initiated recently are Prevention and Treatment of Sexually Transmitted Diseases and Action Against Violence Against Women. These campaigns focus primarily on education, but may also take the form of health camps, exhibitions, etc. They are generally carried out by the CHWs in collaboration with the women's *sanghams*.

The greatest advantage that RUWSEC derives from following this strategy is that the organisation, at all levels, continues to work closely with the community, and all its programmes have evolved out of needs articulated by the community. The strategy of forming *sanghams* and providing leadership training to village women has also meant that, over the years, RUWSEC has created groups that are largely self-sustaining. The members of *sanghams* are not paid any remuneration by the organisation for their involvement, but receive travel and daily allowances when they attend any workshops and/or meetings at RUWSEC's training campus. Their activities are entirely voluntary, and RUWSEC only provides some support of resource materials and technical assistance, if required, for any specific task. These *sanghams* are sufficiently empowered to the extent that they are capable of functioning without much help from RUWSEC.

Expansion of Coverage and Services

After working in the core target area for more than ten years, RUWSEC is ready to seek new horizons and goals — for the organisation as a whole as well as to renew the challenge for each CHW. On the one hand, the current target groups in the existing 43 hamlets no longer need the same level of inputs. On the other hand, there are still so many areas where women's health is grossly neglected and RUWSEC's experience would be invaluable. In February 1996, RUWSEC began expanding its activities to more areas and to other target groups — like older women and single women — in the existing hamlets who had so far been ignored by the programme.

Currently, surveys are being carried out in the newly identified hamlets to plan for service delivery in the future. Village meetings have been held in selected villages to introduce RUWSEC and its activities. Specifically, a survey will be conducted of older and single women in the 43 hamlets where RUWSEC is already working to facilitate an identification of their needs.

Understanding the Local Realities

The baseline survey conducted in 1988 is the starting point for creating and maintaining a database on the health of women and children; this database is consistently updated. The information it contains is required to identify the health problems of poor rural women. It also helps RUWSEC understand the patterns of illness and factors influencing them across villages so that interventions can be planned effectively.

RUWSEC, over the years, has also undertaken a number of local action research studies related to the usefulness of specific health interventions such as distribution of the safe delivery kit and health education during pregnancy. More recently, the organisation carried out a series of focus group discussions in the villages to obtain women's views of the population control programme and their agenda for change. They also carried out a study on the quality of services provided in primary health centres (PHCs) in which several NGOs from

Tamil Nadu participated. The study adopted the participant-observation method where activists went in as patients and made observations with a checklist as guideline. Sixteen health facilities were originally studied and this was further extended by RUWSEC's workers to cover all PHCs in Chengalpattu district. The study found that more improvements are needed in the health facilities, supplies, staffing and services.

The most important aspect of this process is that the research process as well as the consolidation of data are done by the senior health workers of RUWSEC, whose field experiences make their interpretation of data valuable and more insightful. This information is used in health exhibitions, annual health festivals, and as discussion points in village level *sangham* meetings.

RUWSEC has also collaborated with other organisations and researchers to study various key issues in the area of reproductive health. These include users' perspective studies on Norplant acceptors in the city of Chennai (formerly Madras), Tamil Nadu. The users were part of an introductory trial. An experimental intervention in introducing diaphragms in three Chennai slums was also carried out. Data from these studies are documented and circulated to activists and those interested in these issues.

PROGRAMMES FOR ADOLESCENTS AND YOUTHS

Literacy Programme for Girls

Workshop conducted by RUWSEC for adolescent girls

Adolescent girls, as a rule, are left out of various education and intervention programmes because they are considered either too young or old to be in the programmes' target groups. It is thus not a surprise that RUWSEC's household survey found that 60-80 per cent of females in the 11-18 years age group are illiterate and unexposed to life outside the household. To address this problem, the *Magalir Chudar Kalvi* scheme, an education and empowerment programme focused on girls was started in December 1990.

The programme pays close attention to literacy and overall personality and assertiveness development. This programme has been successful in that nearly 100 illiterate adolescent girls reached a level of literacy equivalent to Class IV levels in the regular school within the first two years; another 112 are making steady progress. Thirty-two women with leadership potential, but handicapped by their illiteracy, are now able to read and write. Twenty-two of them are now literacy teachers in their respective villages. The programme made significant progress during 1993-94, with intensive training programmes for 24 girls who wished to complete Class VIII in 1995-96. Starting as illiterates in 1990, these girls have made excellent progress in barely four years.

In addition to learning how to read and write, the girls are educated about their bodies, sexuality and responsibility, contraception and gender relations. This education activity is carried out thrice a year at RUWSEC's training centre.

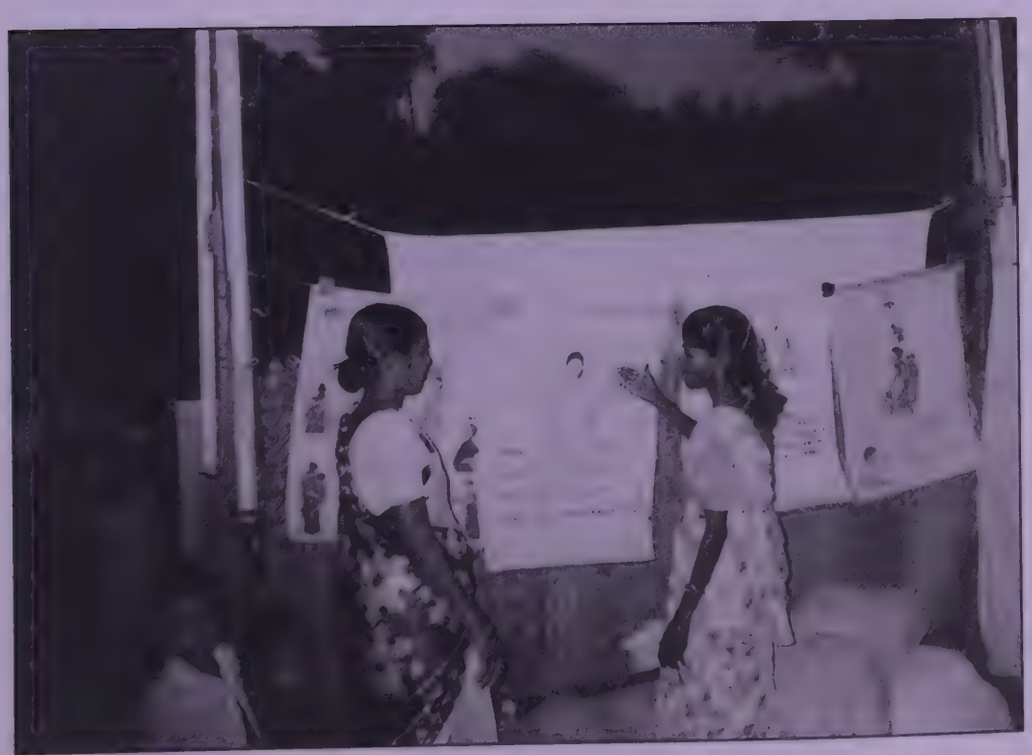
Weekly workshops are also organised to impart leadership skills such as public speaking, group functioning, decision making, taking action on specific local issues and role-playing to create awareness. The workshops aim further to teach the girls about the world around them – including information on *panchayats* (local authority), state structure and electoral process, India and its states, etc. – to enable them to function as effective citizens in the democratic process. In addition, camps and excursions are organised for the girls once in four months. This is to provide them with an exposure to a variety of experiences.

Many of the girls who joined the literacy programme in 1990 are already married, and RUWSEC therefore initiated a contact-programme to keep in touch with them and to respond to their changing needs. This programme has brought to light some new areas for action, such as workshops on marriage and sexuality within marriage, gender relations within marriage, and assertiveness within a joint family context. Another area for future action is to work with the husbands of these girls. At present, the organisation finds that those girls who have been part of the programme have very different expectations of marriage compared to their husbands, who have not been exposed to non-traditional ideas, and this may cause incompatibility and conflict.

The success of RUWSEC's literacy programme resulted in a request from school authorities that RUWSEC help female high school drop-outs complete their final year in school, and also help them to acquire skills leading to better job opportunities. These girls are a target group for expansion of the work related to education and empowerment of adolescents. RUWSEC acted on this opportunity and, in July 1996, started sexual and reproductive health education and services for in-school and out-of-school youth.

Education Programme on Sexuality and Reproductive Health for Youth

After successfully initiating a dialogue with school authorities on sexuality and health education and seeking their involvement from the initial stages, RUWSEC began its School Health Programme. It was central to the implementation of this programme that RUWSEC include the educators as partners, and ensure that the interaction not be adversarial. This programme covers approximately 500 adolescents (250 boys and 250 girls) studying in Class VIII from 10 schools. The decision to target this group was based on the large number of girls who stop schooling after this stage. Many of them, in fact, get married within a year or two after completion of Class VIII.



A stall on women's status set up during a RUWSEC health mela

A two-day orientation workshop was held for RUWSEC's health workers who facilitated the sessions and prepared a list of topics to be covered. This list was presented in a meeting to the headmasters of the participating schools. It was decided that the youth education programme would consist of monthly workshops of two to three hour duration each. Because the headmasters also wanted separate sessions for boys and girls, two men from the "male involvement in gender and reproductive health" project (discussed later) were co-opted as facilitators for the boys.

In a second workshop held in June 1996, a selected group of adolescents was invited to discuss the programme curriculum. From this workshop, it was apparent that girls were more concerned with issues of sexuality and sexual behaviour whereas boys' concerns centred on social behaviours such as smoking and bullying. Based on all these inputs, RUWSEC finalised the curriculum in consultation with teachers and headmasters of the participating schools.

Workshops are ongoing but the programme in its current design has no specific follow-up activities. The organisation plans to start regular health check-ups, counselling on issues related to reproductive and sexual health, pre-marriage counselling and contraceptive advice for both in-school and out-of-school youth in the 43 hamlets currently covered. The expectation is that since these are communities where RUWSEC already has credibility, it would be easier to approach the issue of adolescent and youth sexuality. Initially, the above activities would be carried out through health *melas* or festivals organised in the villages.

Two health *melas* were organised in June 1996 in the government child-care centres of two large villages. A number of stalls with models and posters were set up and run by two health workers. Both adolescent girls participating in the literacy programme as well as other village girls moved around these stalls in groups of 10 and spent between half an hour to one hour in each stall learning about specific topics (see Box A).

BOX A

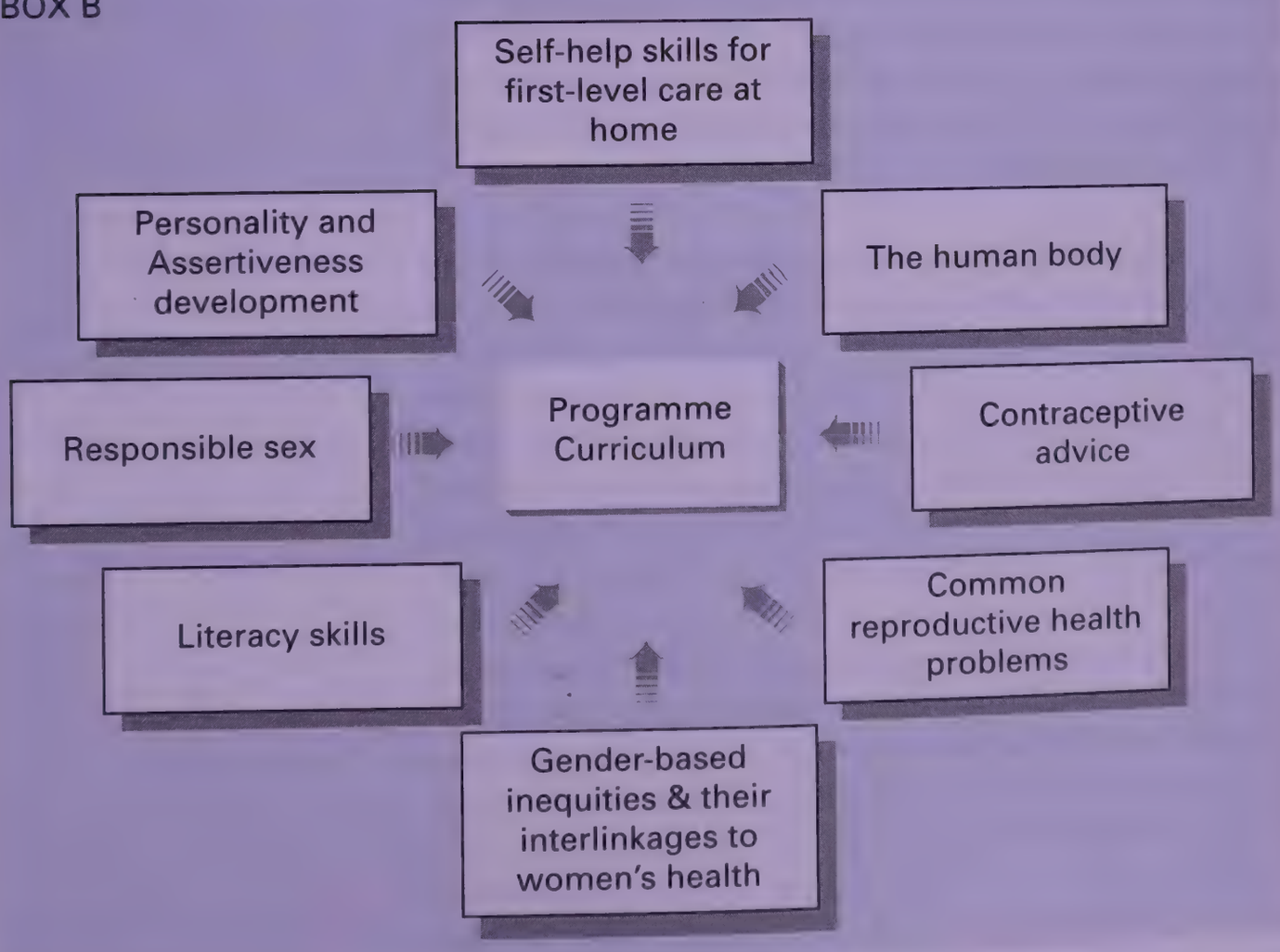
Topics Covered

- Menstrual disorders
- Iron-deficiency anaemia
- Preparing an iron-rich, low-cost cereal mix (demonstration and free cereal porridge were provided to participants)
- Night blindness
- Vaginal white discharge
- Hyperacidity
- Helminthiasis

Reflecting the changing employment structure of the communities, an increasing number of young women, mostly adolescents, are employed in nearby small-scale industries. Many of these young women are illiterate and the majority are, for the first time, spending extended periods outside the village environment without the supervision of elders. Pre-marital sex (coercive or otherwise, unprotected in all instances) and pregnancy among unmarried adolescents are emerging as problems. RUWSEC's workers felt that this was an area they could no longer neglect, and initiated an education programme to help these young women to look after themselves.

The original plan was to start this programme in two factories, but interactions with the managers indicated that they were reluctant to give their workers time off for this activity. Consequently, RUWSEC approached organisations that conduct skills-training programmes for women and arranged for these programmes to include the topics identified in RUWSEC's curriculum for factory workers (see Box B). This

BOX B



strategy appears to be successful. Between March and July 1996, 35 sessions of about two hours duration were held. Presently, six cohorts, the smallest being 15 in number and the largest 35, are attending these sessions. All groups are composed of young women between the ages of 15 and 25 years; and in each group there is a mix of married and unmarried women.

Working with Adolescent Boys

RUWSEC recognises that adolescent boys (11-18 years of age) have so far remained on the periphery of its programmes. Its work with men has shown that this is a critical group and that issues of career and employment, in addition to other concerns that they share with adolescent girls, are major concerns for this age group. Failure in examinations and unemployment push potentially productive male youth to anti-social behaviour.

In 1996 RUWSEC established a youth centre, in a large village, which provides facilities for recreation, education and assistance with school examinations and choice of career. Sex education and health care counselling are also provided. The centre conducts weekly half-day workshops on gender sensitisation and promoting egalitarian gender relations, gender relations within marriage, sexuality, and responsible and safe sexual behaviour.

RUWSEC implements the programme for men and adolescent boys in collaboration with another NGO.

GENDER SENSITISATION AND REPRODUCTIVE HEALTH PROGRAMME FOR MEN

Women's changing expectations and their increasing unwillingness to tolerate a position subordinate to men have accentuated marital conflicts, often resulting in a corresponding rise in domestic violence. Furthermore, in the area of reproductive decision making, while RUWSEC had worked at enabling women to make informed decisions, their partners knew very little about these issues, and this gap also contributed to

marital conflicts. Additionally, data collected in the community by the CHWs on reproductive health problems among women showed that a significant proportion of the reproductive health problems and infections among women were a direct result of the men's promiscuity.

A significant proportion of reproductive health problems among the women were a direct result of the men's promiscuity.

These factors made RUWSEC realise that they were reaching an impasse where their efforts at empowering women were concerned. It was obvious that there had to be interventions for men as well if the programme for women is to succeed. The first step would be to educate men. Subsequently, in 1993, RUWSEC established contact with two local men's groups — Social Development Trust (SDT) and Social Education for Development (SED) — in which husbands of RUWSEC's health workers are actively involved. SDT works intensively with the men in 20 villages in which RUWSEC has been active, and SED conducts workshops in villages covered by other NGOs.

SDT conducted two community meetings a month in each of the 20 hamlets, one for unmarried/adolescent youth and the other for young, married men. The workshops covered topics related to body awareness and sexuality, sexually transmitted diseases and AIDS, common reproductive health problems of men and women, and causes and consequences of male violence against women (see Box C). One specific topic was the main theme focussed upon each month.

SED, on the other hand, conducted workshops in areas covered by four other NGOs. Two years after the activities began, they carried out an evaluation and found that while the programmes were useful, they were barely adequate. It was then recommended that a systematic course of training with several consecutive modules, each leading to the other, be developed to make a greater impact. It was also felt that workshops for the wives should be organised to coincide with the men's workshops.

In response to this feedback, RUWSEC has redesigned its intervention to include a series of seven four-day workshops for men and women. Each workshop is divided into two sessions, each lasting two days; the first two days for men, and the following two days for their wives. Topics covered are similar to those carried out in the village-based programme (see Box C).

BOX C

Programme themes

- Male and female reproductive systems
- Pregnancy and childbirth
- Birth control
- STDs and HIV/AIDS
- Gender relations
- Gender relations within marriage
- Violence against women
- Sexuality and what shapes sexual behaviour
- Expectation from sexual relations and marital conflicts arising from differences (as currently perceived by the men) in sexual needs of the husband and the wife
- Causes and consequences of extra-marital sexual relationships
- Working towards a healthy sexuality.

RUWSEC's experience in implementing the men's programme has been positive, and has not led to any dilution in its existing focus on empowerment of women. Indeed, it has contributed to a better understanding of relationships between men and women and the reasons underlying the conflict which arises. The organisation's learning and experience from dealing with women's issues enrich the men's programme, and the feedback they receive from the male participants has helped identify gaps in the women's programmes and areas for future work.

For these men, this education programme has given them a new awareness. They are more open to seeking treatment for their health problems which may include reproductive and sexual health problems. When they approach the male health workers and/or the trainers of SDT for help, they are referred to RUWSEC's reproductive health clinic, where a senior male doctor is available for consultation on specified days of the week. However, RUWSEC considers that the number of men visiting the clinic with reproductive health problems and infections is still low. Although there is a male doctor, the main obstacle to more men accessing the clinic is the lack of a male STD specialist. This combined with the fact that the clinic has a full-time female doctor and an entirely female staff may be reasons why men are reluctant to visit the clinic. Al-

though RUWSEC plans to rectify this situation and aims to encourage men to utilise these services, the organisation is focussing on treating the partners of women with RTIs/STDs rather than trying to bring in more male clients to the clinic. The STD camps organised for both men and women are more successful as services of both male specialists and female gynaecologists are available.

REPRODUCTIVE HEALTH SERVICES CLINIC

As a result of its health-related activities, RUWSEC found a notable increase in the level of awareness among women about their health problems, as well as willingness to seek medical assistance. This created an overwhelming demand for medical help which the existing public health services could not meet. The organisation found the uncaring and inadequate public health services system, whose resources are limited and whose priorities are not guided by people's needs, to be a formidable obstacle in the attempts to change women's health-seeking behaviour.

Prior to setting up the clinic, a survey of some of the major nursing homes (i.e. those with 10-15 beds and operating facilities, and that are run by private medical practitioners) in Chengalpattu was conducted to evaluate the kind of private medical facilities currently available. The findings showed that most facilities were ill-equipped and badly maintained. They were also overpriced — a simple surgical procedure could cost anything between Rs. 1500.00 to Rs. 10,000.00 (US$46.88 - US$312.50) depending on the doctor and the facility. Most of the nursing homes had senior government doctors as consultants and many of the clients had no choice but to seek services at these homes mainly because the government hospital was not able to meet their needs.

Initially, there were problems marketing RUWSEC's laboratory services to doctors. Private laboratories give commissions for referrals. RUWSEC does not.

There was an obvious need for a clinic that could provide good care at nominal cost. At the same time, RUWSEC had reached a stage where it was essential that an alternative facility for meeting women's health needs had to be provided. This was to be done while RUWSEC's work in lobbying for changes in the present public health care system was to be continued.

Subsequently, with financial support from the MacArthur Foundation, USA, RUWSEC ventured into providing quality services. A five-member medical advisory committee comprising senior medical professionals and public health specialists was formed in March 1995 to (1) guide the establishment of the clinic; (2) act as a continuing source of technical advice and support; and (3) carry out periodic monitoring of the clinical and professional standards of the clinic. After more than a year of preparation, RUWSEC opened its clinic on June 8, 1995 in Chengalpattu.

When the clinic started, only out-patient services were planned. This included diagnosis and treatment for men and women's reproductive health problems including STDs, pregnancy, post-partum care and birth control. Besides counselling and information on birth control methods, the clinic provides access to temporary methods such as oral pills, IUDs and diaphragms.

In response to numerous requests for providing facilities for abortions, deliveries, sterilisation and minor gynaeco-

A doctor examining a client at the reproductive health clinic

logical procedures, RUWSEC approached the Government of Tamil Nadu for financial assistance. The government responded positively and, subsequently, a well-equipped operation theatre was added and the clinic has been performing abortions, deliveries and female sterilisations since April 1996.

The clinic has an average of 500 clients per month. Most of the clients are women and children, but a small number of men seek advice and treatment, mainly for STDs. Nearly 40 percent of the women seek treatment for RTIs and the health workers have been able to follow up and ensure that the former's partners also come for treatment. The success in partner treatment is largely due to the efforts of the health workers in convincing the men that to prevent reinfection to the women and to protect themselves, they need to undergo a prescribed course of treatment. Indeed, the programme for men also facilitates partner treatment. All clients from the target villages receive follow-up attention such as preventive care, request for feedback to the clinic and, if the problem persists, another visit to the clinic for further treatment.

Another important feature of the clinic is the clinical laboratory. This laboratory acts as an independent profit centre and provides testing facilities not only for clients who come to the clinic, but also for those referred to the laboratory by other doctors in the area. Initially, there were some problems with the marketing of the laboratory services to other doctors for referral since the private laboratories give commissions for referrals and RUWSEC, on principle, did not want to follow such a strategy. However, the prices for all the tests were deliberately kept nominal and the quality of the testing was of a high standard. Over a period of time, the laboratory built up a good reputation for itself and, consequently, the number of referrals from outside steadily increased. The lab now conducts over 250 investigations per month. Prices for tests range from Rs. 2.00 (US$0.05) for blood group and haemoglobin to Rs. 15 (US$0.40) for a VDRL.

The clinic has been charging a consultation fee of Rs.5.00 (US$0.16) per client from those coming from target villages and Rs.10.00 (US$0.31) from other villages. Drugs are given at subsidised costs and laboratory tests are done at nominal costs. The laboratory has also started receiving some referrals from other doctors for screening tests.

The clinic currently operates with one full-time and two part-time male and female doctors. The full time staff consist of one senior nurse-administrator, two nurses and a laboratory technician, all of whom are not members of RUWSEC. RUWSEC's health workers were selected and trained as record keeper, receptionist, counsellor/health educator, pharmacist/cashier and laboratory assistant. Initially, all field workers of RUWSEC who had a certain level of literacy and who showed interest in working in the clinic received one-month on-the-job training. The workers who demonstrated maximum aptitude and interest in these tasks were recruited as full-time staff in the clinic.

Health Education and Counselling

Health education is an integral part of the clinic's activities. After receiving treatment instructions from the doctor or the nurse, clients meet the community health worker/health educator for explanation regarding the nature of the problem, causes, self-care, nature of treatment recommended and prevention of reinfection. There is also a trained counsellor available at the clinic who counsels the client on various topics and issues (see Box D). In addition, health education materials are distributed free of cost. Clients are invited to attend the RUWSEC inter-village workshops on reproductive health issues and to participate in its various campaigns.

BOX D

Counselling Services

- Preventive and promotive health practices
- Pre- and post-procedure counselling for sterilisations and abortions, contraceptive advice and guidance
- Any other problems clients might face

Camp and Outreach Clinic

Because RUWSEC felt that STD diagnosis and treatment camps would make services accessible to a greater number of people, it invited the Women Doctors' Association in Chennai and the STD department of the Government Royapettah Hospital to conduct a camp. While more than 300 women and men attended this camp, the quality of services offered was poor, and, drugs were not provided. More importantly, the health workers did not receive proper follow-up instructions and information so they were unable to trace the clients who had attended the camp. As a result, plans for more camps have been put on hold.

Meanwhile, RUWSEC has begun to bring services to the people through its outreach clinics held three times a week according to a predetermined schedule. An ambulance transports the doctor and nurses from one village to the another. The schedule and route plan of the ambulance are known to all field workers and clients.

The ambulance is also used to transport women who have delivered and/or undergone sterilisation back to their villages. There are also a night driver and attendant to respond to any emergencies. The services of the ambulance are also available between 6 p.m. and 6 a.m. to transport clients to other nursing homes and even outside Chengalpattu in case of emergencies. RUWSEC charges a fee of Rs. 3.50 (US$0.11) per km and Rs. 50.00 (US$1.56) for the driver.

Health education session for adolescent girls

Listening to the Community

Two sources exist for feedback from clients: (1) comments from the suggestion box at the clinic; and (2) feedback that village health workers receive from the community. Every Saturday, at a review meeting at the clinic, complaints or suggestions from clients, as well as issues of coordination between the clinic and the other community-based programmes, are discussed. Operation and scheduling of the ambulance as well as quality of care issues are taken up. Minutes of meetings are carefully maintained and at every meeting the minutes of the previous meeting are ratified by those present.

As RUWSEC began working on reproductive health problems, it found that its initial role as a catalyst for changing health-seeking behaviour without being directly involved in health service delivery was increasingly unfeasible. Existing services available to women are limited, and services in the public health system were generally not oriented towards reproductive health. Having worked on demand creation and raising expectations of the community, RUWSEC was faced with an increasingly frustrated client population which was unable to understand why the organisation did not provide reproductive health services at a nominal cost. This is a lesson for organisations that are currently involved or plan to get involved in reproductive health education programmes — they should keep in mind that awareness-generation and education programmes alone may not be effective in changing health-seeking behaviours. They may need to include within the programme a curative services component at some level – they themselves may be the service providers or should establish effective referral system with other service providers.

Demand creation without service provision impedes change to health-seeking behaviour.

RUWSEC had many misgivings about starting a clinic as none of the founding members of the organisation were doctors. Furthermore, hiring and retaining good doctors with an orientation for community work — crucial for the success of the clinic — were not easy tasks. Indeed this has been the most difficult part as RUWSEC has found that most doctors tend to have a patronising attitude towards the community because of the people's socio-economic background. The problem was compounded by the fact that the programme is managed by women from the community and the doctors are expected to report to them. The doctors found it difficult to accept this management system and the organisation could not make an exception for the doctors as this would go against RUWSEC's philosophy. Confronted by these problems, it was nearly a year after the clinic was started that a local female gynaecologist joined the clinic on a full-time basis.

Community-sensitive and receptive doctors are not easily found.

Rational drug use continues to be a matter of concern; the doctors have to be regularly reminded that this clinic is not like private nursing homes and that there should be no attempt to prescribe expensive tests and drugs unless absolutely required. The organisation has found that having a medical advisory committee comprising very senior and respected doctors has been of great help in resolving some of these tricky issues with the doctors on the staff.

Linkages between the community programmes and the clinical programme are stronger if the field workers from the community programmes have regular interaction with the clinic. The organisation provides travel allowance to community health workers who accompany women from the villages to the clinic as this (1) facilitates access to the clinic for many women who would otherwise find it difficult to come to the clinic; and (2) it ensures that client care at the clinic is maintained at levels expected by the community, and (3) it increases a village health worker's sense of responsibility towards a client, and thereby enhancing follow-up. The weekly review meetings also help improve coordination. It is important to include mechanisms that facilitate interaction between the field and the clinical programme as it is easy for the curative programme to lose sight of the community.

Strong linkage with field programmes enhances community-orientation in the clinical programme.

EXPANDING RUWSEC'S IDEAS FURTHER

Scope for Expansion

The nature and structure of NGOs allow only limited expansion. Although RUWSEC had expanded its activities, it wanted to expand further and one of the strategies used has been to work with other NGOs. Presently, the organisation has an ongoing training programme on gender, health and development with four NGOs in Chengalpattu district. This programme consists of a series of seven workshops which involve both men and women from the villages.

Another way of expanding its services is through bi-annual seminars and workshops organised regularly to sensitise women activists from organisations involved in issues other than health to women's health concerns. RUWSEC also reaches out to an audience of about 5,000 to 10,000 men and women through their annual health festival which consists of a health exhibition, film and video shows, cultural programmes and sale of publications. All activities are organised by RUWSEC's workers.

RUWSEC's staff wrote, acted in and directed a play on women's status during RUWSEC's annual festival.

Organisational Challenges

In the course of its evolution, RUWSEC has occasionally faced opposition from various interest groups. Building credibility and trust in the community has not been easy even though all the CHWs are local women. While their task has been made easier in part by the fact that the members of RUWSEC have been involved in a literacy programme, the CHWs have nevertheless been blacklisted or "put out" by the community because their primary agenda is to assert the rights of women, especially where domestic abuse is concerned. The health workers' belief that RUWSEC will support them has been critical in giving them the confidence to take up contentious issues.

The organisation has, at regular intervals, grappled with the question of how much to grow in size, geographical cover-

age and issues to address. One of the biggest challenges facing RUWSEC today is whether it will be able to move to a more structured and systematic way of functioning — required for managing the increasing number of programmes and scope of activities — without losing the energy and motivation it generates from an open, loosely structured and informal environment.

MANAGING THE PROGRAMME

We spend a lot of time organising the festival because we want it to be successful. The visitors have a lot of expectations. We do not want to disappoint them and they are usually happy with the festival. We are proud of the festival.

A RUWSEC staff

Strategy

The key strategy of RUWSEC in serving the needs of the community was to build on its community-based programme for health promotion and on its network of women's *sanghams* (associations). The *sanghams* not only act as catalysts in the community to bring about the desired change in health-seeking behaviours, but they also act as "seed beds" for growth of new ideas. In fact, many of the directions taken by RUWSEC have been a direct result of the feedback and suggestions it has received from these associations.

It is consistent with the history of RUWSEC and the background from which almost all of its founding members came, that the organisation decided to follow a community-based, strategic path. In order to work with the *dalits* it was important that the village health workers are themselves from similar socio-economic and cultural backgrounds. Bringing

in qualified 'social workers' would have created a distance between the organisation and the community. *The organisation's major strength has been and remains its team of local women.* These women are often leaders within their community and serve as useful role models for other women in the village. In fact, many of its senior members have been approached by various local political parties to become candidates for the *panchayat* (local authority) elections.

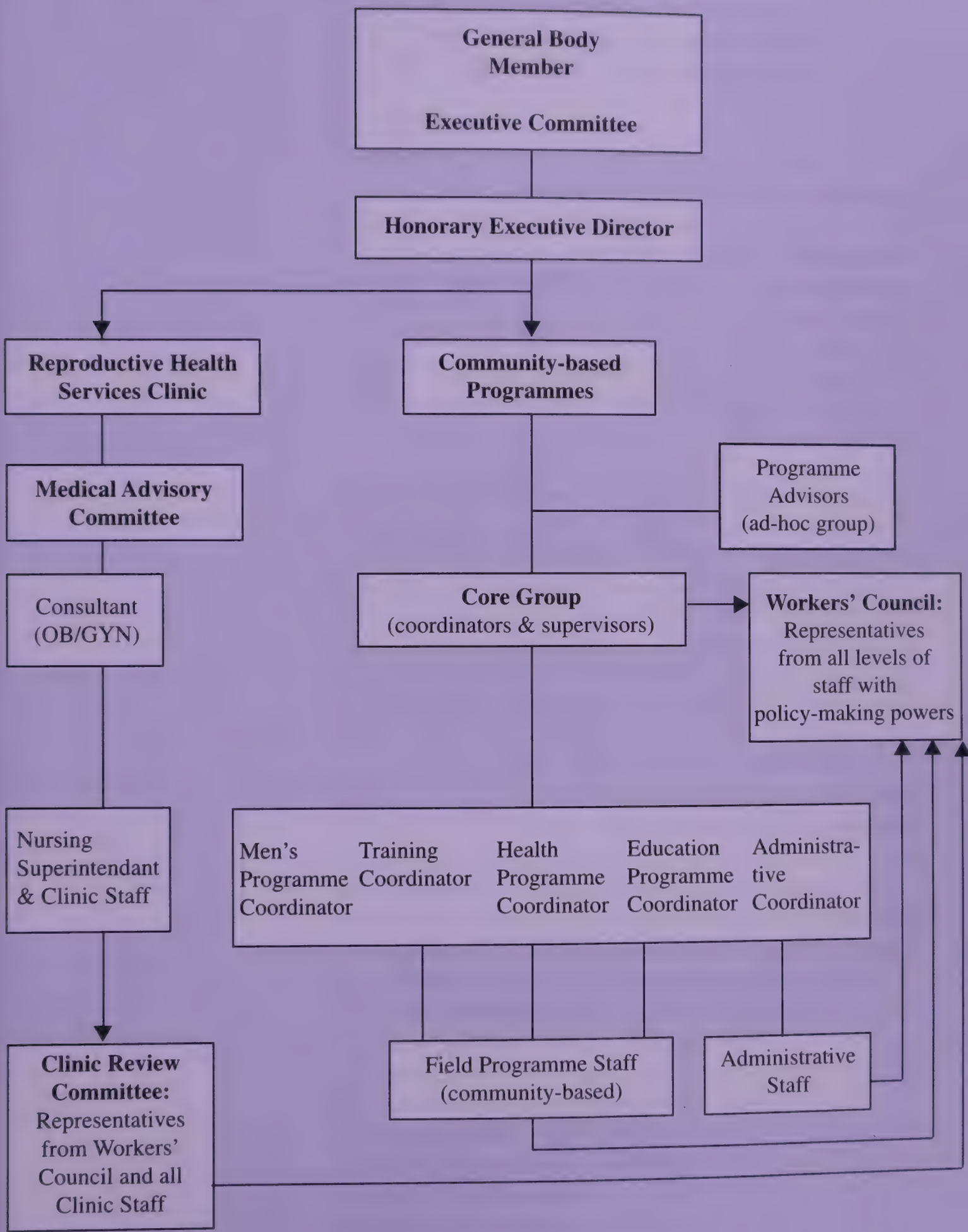
Every programme and activity planned by RUWSEC is discussed by the health workers in their night meetings with the women's *sanghams* and the feedback from these meetings is taken very seriously before finalising any programme. For example, the decision to start in-patient services in the clinic was due to the demand voiced in these meetings. RUWSEC strives to meet the needs of the community and this commitment has significantly strengthened its credibility in the community. Enjoying the trust of the community, RUWSEC is confident in experimenting with sensitive issues and receiving the necessary support from the community. For example, there has been very little resistance to implementation of the adolescent programme.

Organisational Structure

RUWSEC is a registered society with a general body and an elected executive committee which is responsible for major organisational decisions. Members of the Executive Committee are elected by RUWSEC members. Dr. T. K. Sundari Ravindran acts as RUWSEC's honorary Executive Director. She is a founder-member of RUWSEC and has been responsible for its fund-raising, planning, training and major policy decisions. Dr. Sundari is also the secretary of the Executive Committee of RUWSEC and assists the coordinating team with planning and executing activities, besides conducting training programmes for senior staff, monitoring publication activities and coordinating research activities (see Chart 1).

Day-to-day working of RUWSEC is entrusted to a coordinating team — the Core Group — consisting of five members. They plan their respective programmes, implement them, delegate work to supervisory staff and also manage their own budgets as per the budgetary allocations. The total staff strength

CHART 1


General Body Member
Executive Committee
Honorary Executive Director
Reproductive Health Services Clinic
Community-based Programmes
Medical Advisory Committee
Programme Advisors (ad-hoc group)
Consultant (OB/GYN)
Core Group (coordinators & supervisors)
Workers' Council: Representatives from all levels of staff with policy-making powers
Nursing Superintendant & Clinic Staff
Men's Programme Coordinator
Training Coordinator
Health Programme Coordinator
Education Programme Coordinator
Administrative Coordinator
Clinic Review Committee: Representatives from Workers' Council and all Clinic Staff
Field Programme Staff (community-based)
Administrative Staff

is 97 of which 87 are women. Nearly all the workers including the coordinators and supervisory staff are women from the local villages. Starting as health workers 13 years ago, they have risen to positions of responsibility through their work experience and the development of their skills through continuous training.

In addition, there is a Workers' Council, made up of a number of operational committees to:

- monitor the budget and finances;
- develop innovative programme planning;
- monitor staff performance;
- investigate staff grievances and make decisions (within the limitations imposed by the budget provisions);
- mediate in village-level problems that may arise from time to time.

Representatives to the Workers' Council are elected irrespective of age, position or number of years of experience. This gives everyone an exposure to all aspects of running and developing an organisation, allows free airing of views, and maintains a high level of transparency and motivation in the functioning of the organisation. A witness to the council meeting will be struck by the level of enthusiasm and the way in which each worker feels ownership for the organisation and its activities.

Planning and Decision-making

The entire responsibility for the day-to-day planning and implementation of the programme rests with the health workers. They have formed core groups which are responsible for planning and implementing specific tasks or programmes. Each and every programme has an annual plan which clearly specifies objectives for the year, activities to plan, number of activities and the budget. Planning is detailed down to what topic to discuss, what materials would be required and what methodology to adopt. This plan is prepared by the person/team in charge of the programme and is discussed in the Workers' Council before finalisation. The annual plan is then broken into monthly plans which specify activities for the month and how these fit into the annual plan and objectives. Thus,

every member, regardless of his/her level in the organisation has specific programmatic responsibilities and objectives. Planning and decision-making processes are participative and democratic. How well each person is able to plan and implement, as well as, the extent to which he/she is able to meet objectives laid out in the plan is one of the critical areas for performance appraisal.

If there are any changes to be made in the objectives or the activities once a plan has been finalised, the person in charge of the programme has to put forth a revised plan including budgetary changes, if any, and he/she has to clearly specify reasons for the changes. Then, the project coordinator and the core group must ratify such changes. Major changes will be discussed at an executive committee meeting and/or approved by the honorary Executive Director.

Managing Human Resources

The process for staff recruitment is different for different levels. To a large extent, recruitment has been done mainly through contacts of existing health workers or women from existing target-area hamlets. In fact, RUWSEC's experience with recruiting staff through advertisements has not been encouraging. To begin with, the response has not been very good, both in terms of the number of applications and the quality of candidates. It has been easier for the organisation to find suitable local candidates for any vacancies through word of mouth or from the pool of researchers who may have worked on a research project with Dr. Sundari. Nearly all of the staff members are local women and men. While the person in charge of the programme, in consultation with the project coordinator, can appoint recruits such as peons, watchman, etc., senior staff and staff for technical positions (who may or may not be RUWSEC members) have to undergo a final interview with the Executive Director before being appointed.

Performance appraisal is done once a year. All staff, starting from the most junior health worker to the project coordinator, are appraised. At the level of health workers, the appraisal is based on their knowledge as well as on their effectiveness in the field as demonstrated by the performance of their respective villages on various outcome indicators. Senior

staff members who have functional and administrative responsibilities are assessed on how the programmes for which they are responsible have performed as compared to the objectives established in the annual plan. In addition, other members also give feedback on how well the administrative responsibilities have been handled.

The main task has been to retain staff who have the right attitude towards health promotion and to weed out those whose attitudes are incompatible with the rest of the organisation. The organisation has had to take a tough stand on some issues and even to ask some staff to resign. While this has meant that a lot of effort has to go into recruiting and training staff, it has also given the organisation a reputation for being uncompromising in its beliefs and principles. Annual increments and promotions, if any, are given on the basis of this appraisal. There have been instances when some staff have been unsatisfied with the appraisal or have felt victimised. While the organisation makes every attempt to make this process as fair and transparent as possible, if it is felt that the differences between the expectations of a particular staff and the appraisal are irreconcilable, such a person is often counselled to look for other options. In case an employee has a grievance or a complaint she can take it to the Executive Committee, who will then form a task force to look into the issue and report to the Executive Committee.

The atmosphere is intentionally kept informal so that even the newest member is at ease and comfortable enough to be critical about the organisation.

Being an organisation where decisions at all levels are made by the women themselves after a due process of consultation, RUWSEC has over the years evolved staff policies that are sensitive to women's needs and constraints. Their staff are entitled to paid leave for abortion, miscarriage and sterilisation. When women come for any training or meeting and have to bring someone along to take care of their child/children, RUWSEC pays a day's wages to the additional person and takes care of his or her food and transportation expenses. Expenses for any additional children accompanying mothers attending the workshop or meeting are also paid for by RUWSEC, recognising that it is difficult for women to leave the children and come. In case of training programmes lasting several days, when there are three or more

Creating a Gender-sensitive Organisational Culture

RUWSEC sensitises its staff to the kinds of problems faced by women in the villages and to the challenges the staff would face in their task.

Traditionally, women in the villages are never allowed to express themselves and never at all in a public gathering. During the workshops, the women are encouraged to speak out either in a group discussion or as part of exercises in public speaking. The topics for these group discussions and public speaking exercises were such as to help them understand the condition in which they live and the many forms of oppression in women's lives. They are also exposed to stories about women from other countries, and the universality of the oppression faced by women is discussed.

The women are made aware of the need for collective action if any change were to take place in the status of women, but taking action is easier said than done since the women's efforts to form any kind of association will only meet with ridicule at best and active resistance from the men at worst. Fighting this domination by men is more difficult than fighting an external adversary because of the emotions involved since these men were often fathers, husbands or brothers.

children brought by the trainees, the organisation appoints women to take of the children at no extra cost to the trainees.

In addition, RUWSEC has all the provident fund and gratuity benefits as required by the government, which is unusual for a community-based organisation. RUWSEC members can also avail of loans from the organisation. The member has to submit a loan application which is taken up in the Workers' Council meeting and the decision made by the workers' representatives.

While there is an organisational chart and hierarchy, this does not involve great distance between those in the lowest rung, i.e. the village health worker, and the project coordinator or even the core group. It is well recognised and accepted that any woman who shows initiative and interest could

tomorrow be a part of the core group or even lead a project. This leads to a lot of openness and sense of equality. There is very little red tape and while rules and regulations apply to all equally, the atmosphere is intentionally kept informal so that even the newest member is at ease and comfortable enough to be critical about the organisation and its working. Many of the members have been with the organisation for five or more years and all the senior-most staff members are founding members of RUWSEC. The composition of staff and the informal atmosphere has proved to be useful not only in maintaining the client focus of the organisation, but also in helping staff members focus on the overall objective of the organisation.

Transferring this culture to the clinical programme, however, has not been so easy. This is mainly because the doctors and the nursing staff have not been a part of the community-based programmes and do not share the same attitudes towards the clients. Getting them to imbibe the client focus of the organisation has been a long and often difficult process. This continues to be a weak area although some changes are slowly taking place. RUWSEC has hired a local senior doctor who shares RUWSEC's values, and his presence has helped, to some extent, in setting an example. The organisation is planning to work out an arrangement with the teaching hospitals which have a compulsory rural practice requirement for its medical students.

Management Information System

RUWSEC maintains an accurate record of its clients. The process began during 1988-89 when it conducted a baseline survey of all the 3,000 plus households residing in the 48 hamlets covered by its programmes. A folder with a code was created for each household. For example, code 09.43 means that the village code is 09 and the household number is 43. Information in this folder includes (1) socio-economic status and demographic characteristics of the households; and (2) prevalence of health problems among married women in the reproductive age group and young children (0-5 years). The health workers continually update this information during their house visits, scheduled in such a way that every household in the hamlet would be visited at least once a week. More than one visit per week is made to households with special health

needs. In addition, health workers may be approached directly for treatment of a health problem and this information is also recorded. Compiled by the health workers on a quarterly basis, the data collected is used to identify health problems most frequently encountered, to plan appropriate interventions, and to verify whether health activities undertaken so far have had an impact. Similarly, the clinic maintains case sheets for each and every client where all health information is recorded.

Monitoring and Performance Review of the Clinic

Monthly reports of activities implemented are sent by the various programme coordinators to the overall project coordinator. These reports are reviewed against planned activities, and the response to the activities implemented is also assessed. Similarly, the clinic submits a monthly report of total patients (according to age and sex); disease profile; number of referrals and reasons for referral; and number of deliveries, abortions and sterilisations. Copies of all receipts are sent to RUWSEC's headquarters on a monthly basis for audit while cash is tallied on a daily basis.

Drug use is monitored every quarter and any irrational use of drugs not on the recommended list is addressed by the advisory committee. Because of the close links the health workers have with the clinic, there is constant feedback from the community which helps to monitor any irregularities. On the other hand, any problems that the women might have faced while seeking treatment is brought up during the *sangham* meetings and reported to the coordinator of the health programme. This feedback is given to the service providers during the weekly meetings and are in turn forwarded to the clinic.

RUWSEC is currently in the process of setting up a computerised system of monitoring and assessment for its comprehensive reproductive health programme, and has initiated a project for developing field-testing and using process and outcome indicators. Data appropriate to the areas in which activities have been carried out are collected on three outcome indicators: knowledge, health status and practices (see Annex 2). This effort has two inter-related objectives:

- to develop a monitoring and assessment system for RUWSEC's community-based, reproductive health programmes and the Reproductive Health Services Clinic; and

- to develop a system of data collection and record-keeping that can assess the various components of any NGO reproductive health services programme catering to multiple target groups — either community or clinic-based or both.

These indicators are used in the annual review of the Reproductive Health Services Clinic's performance.

Funding and Sustainability of Projects

The community-based programme for health promotion (in existing and new hamlets), the education and empowerment programme for adolescents, and the action research in reproductive health indicators are funded jointly by the Rockefeller Foundation and the Ford Foundation (see Annex 3 for the project costs of the community-based programme and the adolescent programme).

An analysis of the budget for the financial year 1997 for the community-based programme and the programmes for adolescents shows that the older programmes, such as the community-based programme for health promotion, are cost-effective with the cost per capita/per annum working out to around US$1.00. The programmes for adolescents tend to be more cost-intensive. The cost of the adolescent programmes per beneficiary ranges from US$1.82 to US$5.40 for different activities. The equivalent annual cost per capita of the programmes covering the adolescents in the community as a whole work out to US$0.63. The following table provides a summary:

The clinic is funded mostly by a grant from the MacArthur Foundation with some support from the Government of Tamil Nadu for providing sterilisation and abortion. In addition, the direct costs of running the laboratory (cost of reagents and other consumables) and the drug costs are covered by the clients. The income generated from clients referred by other doctors for routine tests helps to cover part of costs such as salary. Aware that it cannot rely on grants indefi-

Programme	Population covered	Annual cost per capita (US$)	Number of beneficiaries	Cost per beneficiary (US$)
Community-based health education and services	24,548	1.12		
Programmes covering adolescents in the population of 15,000	15,000	0.63		
Adolescent programmes				
• **In-school health education (10 schools)**			560	3.13
• **Workshops for adolescent girls (43 hamlets)**			660	5.32
• **Health and counselling services (43 hamlets)**			1,400	1.82
• **Life skills programmes for female factory workers**			300	5.40
Exchange rate US$1.00= Rs. 32.00				

nitely, the management constantly seeks ways to improve financial sustainability. Efforts towards financial sustainability have so far included ambulance service and renting out the operation theatre to other doctors for minor procedures.

Given the socio-economic status of the community served by RUWSEC, full financial sustainability through cost recovery from the community for its programmes, particularly the community-based programmes, does not appear feasible. On the other hand, RUWSEC has developed the technical, managerial and organisational capacity of the local population to the extent that they are able to run programmes on their own. For example, the women's *sanghams* are largely self-sus-

Street theatre by CHWs in a village sangham meeting

taining interest groups of local women who are capable of continuing health promotion work with minimum external inputs. Similarly, in the case of their work with men, RUWSEC opted to work through two existing local groups whom they trained and equipped for the task.

Impact of the Projects

From the reports of the health workers and the household data maintained by RUWSEC, it can be seen that the organisation's strategy for health promotion has been fairly successful in altering health-seeking behaviour:

- The women's *sanghams* have boosted demand for immunisation; immunisation coverage is now well above 80 per cent in the project area.
- Wells are regularly maintained and are clean, and prompt action ensues in case of an epidemic.
- Fewer children get diarrhoea, and there have been no deaths from it since adherence to oral rehydration therapy (ORT) is now a way of life.
- Hospital-based deliveries have risen up from a mere 25 per cent to about 49 per cent between 1989 and 1991. Hospital deliveries of 'at risk' cases have increased to nearly 80 per cent.
- An increasing number of women are seeking medical help and also initiating self-treatment through herb-based home remedies for RTIs. The women are taught to treat themselves with local herbs, which have been very effective in some vaginal discharge and menstrual problems, so that they

need to seek medical help only for persistent infections. Such treatment is monitored by RUWSEC's CHW and if she feels the self-treatment is inappropriate, then she refers the woman to the RUWSEC clinic.

- Atrocities against women are rarely left unchallenged. Medical abuses and inaction in health centres are reported regularly and local-level action will attempt to deal with the complaints.

LESSONS AND ISSUES FOR UPSCALING

An NGO with strong community linkages can replicate RUWSEC's reproductive health programme, but the government would find it difficult to implement such a programme.
RUWSEC's experience has shown that empowerment and education generate demand for services. In this connection, NGOs may want to consider mechanisms for service delivery. Setting up a clinic modelled along the lines of the RUWSEC clinic is one option. Alternatively, the NGO could collaborate with existing private providers to run satellite/outreach clinics or even regular camps.

The government, however, may find it difficult to manage a community-based programme of RUWSEC's kind for the following reasons. First, the government auxiliary nurse midwives (ANMs), who are the service providers at the village level, are not necessarily from that village and, in most cases, are not resident in the village. Thus, they lack bonding with the community. Second, their focus is not on client needs, but on family planning which almost always means sterilisation. Third, the primary health centres are not equipped to provide the kind of reproductive health services available at a RUWSEC clinic because of:

- lack of staff, especially female medical officers;
- inadequate or inappropriate equipment — many PHCs do not have speculums and gloves;
- lack of drugs including antibiotics;
- staff are not trained to provide comprehensive reproductive health services;
- negative attitudes of service providers towards clients.

Given these factors, it may be useful for the government to consider providing service delivery support to NGOs that are running community-based programmes for health promotion. Smooth implementation of this collaboration calls for both NGOs and the authorities to clearly share expectations and also recognise each other's strengths and limitations.

Community-based programmes versus professionally managed programmes. The success of RUWSEC's community-based programmes also owes a lot to the historical context in which it started. Its basic strategy of selecting local women and forming women's groups is replicable, but may need to be adapted to the existing structure and programmes of another NGO. Similarly, RUWSEC has not had professional managers to implement its programme since its inception. It has instead relied on building the technical, administrative and managerial skills of health workers who have shown leadership qualities. This has contributed to motivation, dedication and ownership of the organisation's work. However, an NGO that already has professional managers and has a culture of recruiting managers from outside for coordinating their programmes may not find this a feasible strategy.

On the other hand, the question of whether non-professionals are able to handle the complications of managing a reproductive health programmes can be raised. If recruitment of professional staff is necessary, recruiting them may create resentment and tension between existing grassroots managers and the latter. Should this becomes a problem, the organisation needs to find a compromise or a middle ground to bridge the differences.

Clinics should be managed by non-physician staff. The Reproductive Health Services Clinic is managed by a senior nurse while the doctor concentrates on the medical aspects. This strategy, applied by successful urban reproductive health clinics,[1] enables the doctors to spend more time with the clients as they do not have to worry about clinic administration. This strategy can be adopted by both NGOs and the government. Presently, medical officers at the government PHCs function as service providers as well as administrators. Filling in forms,

[1] Prof. Jay Satia and Moi-Lee Liow. "Managing Urban Reproductive Health Clinics." *Population Manager*, Volume 2, ICOMP, 1995.

completing reports and attending meetings take a large portion of the medical officer's time which could be used to attend to clients.

Monitoring and assessment of programmes using simple data-collection tools which can be used by health workers to help them plan and monitor their activities have been a major strength of RUWSEC. Government and NGO programmes would be able to increase programme effectiveness by examining and adapting this system to their own requirements.

Empowerment leads to demand: need for availability of services. After RUWSEC began educating the community about general health and reproductive health, the community eventually demanded services. Although RUWSEC initially debated whether or not to meet the demand, it decided to give what the community wanted. Not meeting the demand of the community could have resulted in a backlash against RUWSEC. On the other hand, like many other NGOs, RUWSEC aims to recruit and retain personnel who share the organisation's philosophy and commitment to quality services. As mentioned earlier, it has taken strong actions including dismissing those who divert from RUWSEC's philosophy. While this approach helps to ensure quality of care, it also poses several problems. As with doctors, other personnel's availability to work in the rural setting is already a problem. Dismissal of staff means waste of training efforts and investments. These are issues which NGOs need to think about when they consciously or inadvertently generate demand from the community.

Develop staff commitment to client-centred approach. The greatest challenge that the government will face in implementing any of these innovations will be inculcating a client-centred approach and training the staff to treat clients with dignity. Also, each member will have to be oriented to performing his or her tasks with minimum supervision and a commitment to quality of care which comes from accountability to the community for the services provided.

Opportunities for government-NGO partnership. NGOs such as RUWSEC have had a head start in experimenting with providing innovative reproductive health education and services to the community. Through this experience, it has collected a

wealth of data and information. These experiences offer the Government an opportunity to build on their strengths. The World Bank supported Reproductive and Child Health Programme offers opportunities for the government to collaborate with NGOs, such as RUWSEC, where the latter could provide technical assistance in terms of training of health workers and establishing systems for monitoring and collecting data in the community. In fact, RUWSEC is already involved in:

- developing and pilot-testing clinic and community-based record-keeping systems, both in computerised and manual forms;
- using the systems to evaluate the impact of specific interventions; and
- producing a manual on the development and use of clinic and community-based record-keeping systems for reproductive health programmes.

RUWSEC has also taken advantage of this opportunity by requesting financial support from the Government of Tamil Nadu for Safe Motherhood services. Thus, a government-NGO partnership could build on each other's strengths. □

HEALTH PROBLEMS AMONG WOMEN

Table 1: Prevalence and Frequency of Health Problems Among Women of Reproductive Age, Chengalpattu District, Tamil Nadu (1990-91)*

	Reproductive health problems	General health problems	All health problems	No health problems	TOTAL
No. of women	170 (17.4)	378 (38.7)	442 (45.2)	535	977
No. of episodes	353 (26.4)	985 (73.6)	1338	–	–
Average no. of episodes/women affected	2.1	2.6	3	–	–

*Data based on symptomatic diagnosis during regular house visits by community health workers of RUWSEC in 20 hamlets of the organisation's target area, during two comparable four-month periods, February-May 1990 & 1991.

Table 2: Nature of Reproductive Health Problems, Prevalence and Recurrence Among Women of Reproductive Age: Chegalpattu District, Tamil Nadu (1990-91)*

Reproductive health problems	No. of women	Per cent (of those affected)	No. of episodes	Per cent (of total episodes)	Average no. of episodes/ woman
Menstrual disorders	17	10.0	23	6.5	1.4
RTIs†	99	58.0	220	62.3	2.2
RTIs in women with uterine prolapse	2	1.2	10	2.8	5.0
RTIs in women with urinary incontinence	2	1.2	7	2.0	3.5
RTIs in pregnant women	4	2.4	13	3.7	3.3
RTIs post-partum	2	1.2	2	0.6	1.0
RTIs following surgical sterilisation for FP	6	3.6	9	2.5	1.5
Urinary tract infections	27	15.9	34	9.6	1.3
Urinary tract infections in women with urinary/incontinence	3	1.8	26	7.4	8.7
Bleeding during pregnancy	2	1.2	2	0.6	1.0
Pitting oedema in pregnancy	6	3.6	7	2.0	1.2
All causes	170	100◆	353	100.0	2.1

† Syndromic diagnosis based on WHO definitions

* Data are based on symptomatic diagnoses during regular house visits by community health workers

◆ Rounded-off to whole number

REPRODUCTIVE HEALTH INDICATORS

Outcome indicators	Data collected
1) Knowledge	Increase in the proportion of women in the community who know about: • Immunisation for children and pregnant women; • Basic steps to take in case of diarrhoea, fever and acute respiratory infections especially in infants and children; • Basic menstrual hygiene; • What antenatal care to seek; • Danger signals during pregnancy, delivery and post-partum; • Different contraceptive methods and how they work (at least one spacing method); • Significance of white discharge when associated with different symptoms or risk factors, and what to do about it; • Symptoms of STDs in men and what to do about it; • Symptoms of other reproductive health problems and infections like PID, uterine prolapse, fibroids, symptoms of breast and cervical cancers etc., and what to do about them; • How to protect oneself from domestic and sexual violence and where to seek help; and • Optimal and informed use of health services: neither neglect nor dependence on a pill for every illness.

Note: As part of the project for developing indicators for reproductive health programmes, RUWSEC is in the process of evolving indicators that are gender-sensitive and indicative of women's control over their own bodies.

Outcome indicators	Data collected
2) Health Status	• Decline in the incidence of communicable diseases in the community; • Decline in negative pregnancy outcome, infant and child death; • Decline in infant and child morbidity (no. of episodes of illness); • Decline in the proportion of malnourished children; • Decline in the proportion of malnourished girls (5-15); • Decline in the proportion of women with nutritional anaemia; • Decline in morbidity among girls in the 5-15 age group • Decline in morbidity during pregnancy, delivery and post-partum and in morbidity related to abortions and miscarriages; • Decline in episodes of reproductive morbidity, and non-recurrence of episodes in the same persons (women and men to the extent information is available); • No event of maternal mortality; • Decline in the proportion of women with a space of less than 2 years between the last two deliveries; • Reduction of unwanted pregnancies to almost nil; • Decline in episodes of domestic violence leading to physical injury; and • Reduction to almost nil of number of persons with no help/ treatment/support for mental health problems and for serious illnesses or for disabilities.

Outcomes indicators	Data collected
3) Practices	Increase in • Number of villages where the drinking water source is kept clean and operational; • Number of villages where waste disposal measures are in place; • Number of villages where there is no stagnant water; • Number of villages where a drainage system is operational and there are no open streams of dirty water; • Number of villages where the source of water for washing and bathing is an open pond; • % of mothers who breasted their infants from the first day; • % of mothers who continue exclusive breast-feeding up to the three months; • % of mothers who introduce home made weaning foods by three months; • % of infants completely immunised at the right time (by sex); • % of infants and children treated with ORT during the previous episode of diarrhoea (by sex); • % of infants and children treated appropriately during the previous episode of fever and/or acute respiratory infection (by sex); • % of households with children that do not permit defecation near the house; • % of women who have had antenatal care during the recent pregnancy; • % of women who have had an unsafe abortion during the last pregnancy; • % of women using a safe delivery kit; • % of pregnant women who were attended by a trained person for delivery; • % of women who developed complications in pregnancy/delivery who sought medical help/institutional delivery; • % of women practising contraception; • % of men practising contraception and/or using condoms (need not be for contraception); • % of women and men seeking medical help for reproductive tract infections and STDs; • % of girls (5 to pre-marriage), older women and single women who receive medical help/other appropriate health care in case illness; • % of women seeking help for a mental health problem, receiving appropriate help and complying with treatment successfully; • % of those with serious health problems who get appropriate medical help and complete treatment; and • % of those with disabilities who received appropriate help.

COST OF COMMUNITY-BASED HEALTH EDUCATION AND SERVICES

Table 3: Cost Breakdown by Items of Expenditure

	1996-1997 Rs.	1996-1997 US$
A. Salaries		
Health workers (20) (existing areas)	168,000	5,250
Health workers (12) (expansion area)	144,000	4,500
Team leaders (4) (expansion areas)	57,600	1,800
Project coordinator (1)	36,000	1,125
Core Group (7 members)	145,000	4,556
Administrator (1)	20,400	638
Accountant (1)	19,200	600
Office Assistants (2)	22,200	694
Staff benefits (provident fund & gratuity)	106,900	3,341
Sub-total (A)	**720,100**	**22,503**
B. Training		
Outside RUWSEC (15 persons p.a.)	45,000	1,406
In-house (44 persons x 18 days p.a.)	112,500	3,516
Sub-total (B)	**157,500**	**4,922**

Table 4: Cost Breakdown by Programmes

	1996-1997 Rs.	1996-1997 US$
A. School health education programme (10 schools)		
Curriculum planning and teaching/learning aids	21,000	656
Travel costs for health workers	14,000	438
Events	21,000	656
Sub-total (A)	**56,000**	**1,750**
B. Workshops for adolescent girls (43 hamlets)		
Training and counselling materials preparation and publication	35,000	1,094
3 workshops/year @Rs.500, Rs.550 and Rs.600	77,400	2,419
Sub-total (B)	**112,400**	**3,513**
C. Health and Counselling Services for Adolescents (43 hamlets)		
Field costs for organizing 2 health check-ups/year/hamlet (Rs.500, Rs.550 and Rs.600)	51,600	1,613
TA and DA for health personnel (43 x 2 visits/year)	15,000	469
Drugs costs for treatment	15,000	469
Sub-total (C)	**81,600**	**2,550**

D. Work-place based programme for young women		
Salaries for two literacy-cum health educators	30,000	938
Training of educators (in-house, 18 days a year)	2,400	75
Travel costs	12,000	375
Events/special campaigns	3,000	94
Health check-ups (once a week)		
Travel	2,200	69
Drug (subsidy)	2,200	69
Sub-total (D)	**51,800**	**1,619**
Total (A + B + C + D)	**301,800**	**9,431**
Aproximately US$1.00 = Rs. 32.00		

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